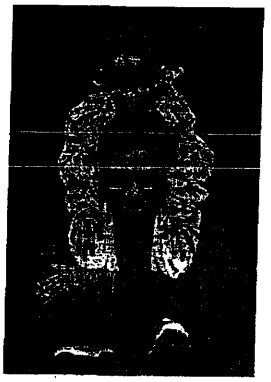


Group Health Care Plan

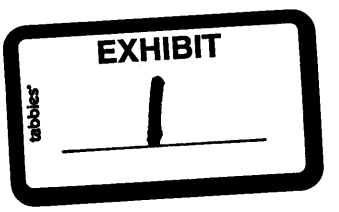
Hyundai Motor Manufacturing Alabama, LLC

High Option

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Effective January 1, 2004



WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you we will provide the best service we can in the administration of your group health and dental care plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits. There are sections explaining eligibility and defining certain words, too. Please be sure to read this information in its entirety. This information is a "summary plan description" or "plan" as defined by ERISA, the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974 as amended.

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of **independent** Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and HMMA will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions which the person in your company who deals with Team Member benefits cannot answer, please contact the Blue Cross and Blue Shield of Alabama Customer Service Department.

Attention Please This booklet contains a summary in English of your plan rights and benefits. If you have difficulty understanding any part of this booklet, contact Blue Cross and Blue Shield of Alabama's Customer Service Department at 1-800-292-8868 *(or the group's dedicated Customer Service number)*. Office hours for Customer Service are from 8:00 a.m. to 5:00 p.m. Monday through Friday, CST (Central Standard Time). You may also contact your plan administrator or HMMA's benefit office for more information.

Atencion Por Favor - SpanishEste folleto contiene un resumen en Ingles de su beneficios y derechos del plan. Si usted tiene dificultad entendiendo cual quier parte de este informacion, por favor ponese en contacto con el Departmento de Servicio Cliente de Blue Cross y Blue Shield de Alabama a 1-800-292-8868, o al gratis numero del telefono localizado detras de su tarjeta de identificacion de Blue Cross y Blue Shield de Alabama. Las horas del officina son Lunes hasta Viernes, 8:00 a.m. hasta 5:00 p.m. central normal corriente tiempo. Tambien puede ponerse en contacto con su administrador del plan o la officina del beneficio de su patron para mas informacion.

Group Number 48584

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SUMMARY OF HEALTH BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan:

To maximize your benefits seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1-800-810-BLUE (2583) or access our website at www.bcbsal.org to find out if your provider is a PPO member.

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 4 of "Benefit Conditions."

INPATIENT HOSPITAL		
Benefit	**PPO**	**Non-PPO**
Coverage	365 days of care during each confinement*; 100% of the PPO Allowance for covered inpatient expenses, no deductible	365 days of care during each confinement*; covered in Other Covered Services at 80% of the Allowed Amount, subject to the calendar year deductible**
Preadmission Certification	Required for all admissions except maternity; emergency admissions require notification within 48 hours of admission; **for precertification call 1-800-248-2342 toll-free**	
Inpatient Mental and Nervous/Substance Abuse	100% of the PPO Allowance; limited to 45 days each 12 consecutive months*	80% of the Allowed Amount; limited to 45 days each 12 consecutive months*

* If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; inpatient hospital days are limited to a combined PPO and Non-PPO maximum of 365 days for each confinement; mental and nervous disorders (including substance abuse) are limited to a combined PPO and Non-PPO maximum of 45 days; no coverage is available for mental and nervous disorders under Other Covered Services after the 45 days are used.

OUTPATIENT HOSPITAL *		
Benefit	**PPO**	**Non-PPO**
Accidental Injury	100% of the PPO Allowance, no deductible or copay applicable	100% of the Allowed Amount when services are rendered within 72 hours of the accident; after 72 hours, 80% of the Allowed Amount, subject to the calendar year deductible
Medical Emergency	100% of the PPO Allowance, subject to a $25 facility copay	100% of the Allowed Amount when services are rendered within 72 hours of onset of the illness; after 72 hours, 80% of the Allowed Amount, subject to the calendar year deductible
Surgery	100% of the PPO Allowance, subject to a $25 facility copay	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic Lab and X-ray, IV Therapy, Radiation Therapy and Chemotherapy	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

* Benefits will be determined under "OTHER COVERED SERVICES" in the Summary of Health Benefits and Health Benefits sections of this booklet for (1) services in the emergency room if the patient's condition does not meet the definition of a Medical Emergency, and (2) outpatient services not listed in this table.

PREFERRED HOME HEALTH AND HOSPICE BENEFITS*		
Benefit	PPO	Non-PPO
Preferred Home Health and Hospice Care Within the State of Alabama	100% of the PPO Allowance, no deductible	Not covered
Preferred Home Health and Hospice Care Outside the State of Alabama	100% of the PPO Allowance, no deductible; **precertification is required - call 1-800-821-7231**	80% of the Allowed Amount, subject to the calendar year deductible; the remaining percentage applies toward the annual out-of-pocket maximum; **precertification is required - call 1-800-821-7231**

* Any covered expenses for Preferred Home Health Care and covered Non-PPO expenses for Preferred Hospice Care apply toward the lifetime maximum.

PHYSICIAN SERVICES		
Benefit	PPO	Non-PPO
Surgery and Anesthesia, In-Hospital Visits, Second Surgical Opinions and Inpatient Consultations	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic X-Rays and Lab Exams	100% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Office Care Services, Emergency Room Services and Outpatient Consultations	100% of the PPO Allowance, subject to the $15 office copayment	80% of the Allowed Amount, subject to the calendar year deductible

PREVENTIVE CARE SERVICES		
Benefit	PPO	Non-PPO
In-Hospital Routine Newborn Care	100% of the PPO Allowance, no deductible or copayment	Not covered
Routine Well Child Care	100% of the PPO Allowance, subject to the $15 copayment; includes coverage for nine visits during the first two years and one visit per year thereafter through age six	Not covered
Routine Immunizations	100% of the PPO Allowance, no deductible or copayment	Not covered
Routine Pap Smears	100% of the PPO Allowance with no deductible; limited to one per calendar year for females	Not covered

PREVENTIVE CARE SERVICES - Continued		
Benefit	**PPO**	**Non-PPO**
Routine Mammogram **See Mastectomy and Mammograms (later in this booklet) for additional information**	100% of the PPO Allowance with no deductible; limited to one exam for females ages 35-39 and one per year for females ages 40 and over	Not covered
Routine Prostate Specific Antigen	100% of the PPO Allowance; limited to one exam per year for males ages 40 and over	Not covered

GENERAL PROVISIONS	
Benefit	
Calendar Year Deductible	$100 per person per calendar year; $200 per family*
Annual Out-of-Pocket Maximum	$500 per person, $1,000 per family (applicable to Other Covered Services) including the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	$2,000,000 lifetime maximum for each covered member; applies only to Other Covered Services, Non-PPO Outpatient Hospital Services, Non-PPO Physician Services, Mental Health and Substance Abuse Physician Services unless otherwise stated***

* Only one deductible is required when two or more family members have expenses resulting from injuries received in one accident.

** Non-covered expenses and expenses for Mental Health and Substance Abuse do not apply toward the Annual Out-of-Pocket Maximum.

*** Expenses for accidental injury rendered within 72 hours of the accident in the outpatient department of a Non-PPO facility do not apply toward the Lifetime Maximum.

OTHER COVERED SERVICES	
Benefit	
Durable Medical Equipment (DME)**	**Preferred DME Supplier in Alabama:** 80% of the Preferred DME Supplier Fee Schedule; subject to the calendar year deductible **Non-Preferred DME Supplier in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **DME Supplier Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible
Physical Therapy**	**Preferred Physical Therapist in Alabama:** 80% of the Preferred Physical Therapist Fee Schedule; subject to the calendar year deductible **Non-Preferred Physical Therapist in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **Physical Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible
Ambulance Service	80% of the Allowed Amount, subject to the calendar year deductible
Inpatient Mental and Nervous/Substance Abuse	80% of the Allowed Amount, subject to the calendar year deductible; limited to 45 visits each 12 consecutive months
Outpatient Mental and Nervous	80% of the Allowed Amount, subject to the calendar year deductible; limited to 20 visits each calendar year

OTHER COVERED SERVICES - Continued	
Benefit	
Outpatient Substance Abuse	80% of the Allowed Amount, subject to the calendar year deductible; limited to a maximum payment of $2,000 each calendar year
Chiropractic Services	80% of the Allowed Amount; subject to the calendar year deductible
Occupational Therapy Services for the Hand and/or Treatment of Lymphedema **	**Preferred Occupational Therapist in Alabama:** 80% of the Preferred Occupational Therapist Fee Schedule; subject to the calendar year deductible **Non-Preferred Occupational Therapist in Alabama:** 80% of the Allowed Amount; subject to the calendar year deductible **Occupational Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state; subject to the calendar year deductible
Allergy Testing and Treatment	80% of the Allowed Amount, subject to the calendar year deductible

* See Other Covered Services in the Health Benefits section for additional services. Most Other Covered Services are paid at 80% of the Allowed Amount after the calendar year deductible is met.

** When using a Preferred or Participating Provider, the provider will bill us and we will pay him or her directly. If you see a Non-Preferred or Non-Participating Provider, you may have to file your claim and you will be responsible for charges in excess of the Allowed Amount.

PRESCRIPTION DRUGS*	
Benefit	
Prepaid Prescription Drug Program	$5 copay for generic; $10 copay for Preferred brand; $20 copay for Non-Preferred brand * See Prepaid Prescription Drug Benefits for a listing of the diabetic supplies included

BABY YOURSELF PROGRAM	
Benefit	
Baby Yourself	A prenatal wellness program with high-risk pregnancy early intervention

EXPANDED PSYCHIATRIC SERVICES		
Benefit	**PPO**	**Non-PPO**
Inpatient Expanded Psychiatric Services	100%, no deductible or copay; up to 30 days of inpatient care each year when a member visits a Participating Expanded Psychiatric (EPS) Facility for mental and nervous disorders or treatment for chemical dependency	See Inpatient Hospital Benefits in this Summary
Outpatient Expanded Psychiatric Services	100% for outpatient mental health and chemical dependency (alcohol and drug abuse) care or treatment when a member visits a Participating facility	See Outpatient Mental and Nervous/Substance Abuse

INDIVIDUAL CASE MANAGEMENT	
Benefit	
Individual Case Management	Services available through Comprehensive Managed Care; see the Individual Case Management section for details

VISION CARE BENEFITS	
Benefit	
Vision Care	80% of the Allowed Amount, no deductible; limited to $250 per person each calendar year

ELIGIBILITY AND PRE-EXISTING CONDITION EXCLUSION PERIODS

Who Is Eligible for This Plan?

You are eligible to enroll in this plan if all of the following requirements are satisfied:

1. you are a regular Team Member of HMMA and are treated as a regular Team Member (as opposed to, for example, an independent contractor, leased employee, seasonal employee, co-op student, intern, or temporary employee, all of which are not eligible for, and are specifically excluded from, this plan) by HMMA;
2. you work 40 or more hours per week (including vacation and certain leaves of absence that are discussed in the section below dealing with termination of coverage);
3. you are in a category or classification of Team Members that is covered by the plan;
4. you meet any other eligibility or participation rules established by us or HMMA; and,
5. you satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Is There A Waiting Period Under The Plan?

There is no waiting period under the plan. This means that you may enroll in the plan once you have met the eligibility requirements listed above. Coverage will begin on the date specified below under "When Does Coverage Begin?"

How Do I Apply for the Plan?

Fill out an application form completely and give it to HMMA or group. You must name all eligible dependents to be covered on the application. HMMA or group will collect all of the Team Members' applications and send them to us.

Which of My Dependents Is Eligible?

Your eligible dependents are:

1. your spouse (of the opposite sex);
2. an unmarried child under age 19;
3. an unmarried child age 19 to 25 while a full-time student in a state accredited school, not working full-time and chiefly depending on you for support; and,
4. an incapacitated child who is not able to support himself and who depends on you for support, if the incapacity occurred before age 19 (or 25 if a "full-time student").

The child may be:

1. a natural child;
2. a stepchild residing in the household of the eligible Team Member;
3. a legally adopted child;
4. a child placed for adoption; or,
5. any other unmarried child for whom the Team Member has permanent legal custody and who depends solely on the Team Member for support and regularly and permanently resides with the Team Member in a parent-child relationship.

A grandchild is only eligible if he or she meets all of the following guidelines: (1) under 19 years of age; (2) unmarried; (3) chiefly dependent on the Team Member for support; (4) resides in the same household full-time with the Team Member in a parent-child relationship; and (5) is not employed on a regular full-time basis. The grandchild's parent may not be covered by the Team Member's contract unless the grandchild has been adopted by the grandparents and the parent meets all of the other conditions to be covered as a dependent.

When Does Coverage Begin?

Regular Enrollment:

If you apply within 30 days after the date employment begins, your coverage will begin on the date you apply. If you are a new Team Member, coverage will not begin earlier than the first day on which you report to active duty. A Team Member who enrolls under this paragraph is called a "regular enrollee."

Late Enrollment:

You may also enroll as a "late enrollee" during your group's annual open enrollment period. Your coverage will begin on the date specified by your group following your enrollment. A late enrollee is any member who doesn't enroll during the regular enrollment period described above or during a special enrollment period.

Special Enrollment Period for Individuals Losing Other Coverage:

A Team Member or dependent (1) who doesn't enroll during the first 30 days of eligibility because the Team Member or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of HMMA to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective as of the date on which the other coverage ended. A member who enrolls under this paragraph is called a "special enrollee."

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for cause (for example, making a fraudulent claim or intentional misrepresentation of a material fact).

Special Enrollment Period for Newly Acquired Dependents:

> If you have a new dependent as a result of marriage, birth, placement for adoption, or adoption, you may enroll yourself and/or your spouse and your new dependent as special enrollees provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of marriage, birth, placement for adoption, or adoption. A member who enrolls under this paragraph is also called a "special enrollee."

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.

Will I Be Subject to a Pre-Existing Condition Exclusion Period?

No. There is not an exclusionary period for pre-existing conditions.

Will the Plan Cover a Child if Required to do so by Court Order?

If HMMA (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, HMMA will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the Team Member's child regardless of whether the Team Member has enrolled the child for coverage. HMMA has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the HMMA at the address shown near the end of this summary.

The plan will cover a Team Member's child if required to do so by a QMCSO.

If HMMA determines that an order is a QMCSO, Blue Cross will enroll the child for coverage effective as of a date specified by HMMA, but not earlier than the later of the following:

1. If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from HMMA to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.

2. If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from HMMA to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the child's attainment of age 19 or age 25 if a "full-time student." If the Team Member is required to pay extra to cover the child, HMMA may increase the Team Member's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law. For example, a child covered by a QMCSO may be subject to a pre-existing condition exclusion.

While the QMCSO is in effect Blue Cross will provide benefits directly to the child or the child's custodial parent or legal guardian. Blue Cross will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. Blue Cross will also send claims reports directly to the child's custodial parent or legal guardian.

If I Work after Age 65 or Become Eligible for Medicare, Am I Still Covered?

If you continue to be actively employed when you are age 65 or older, you and your spouse will continue to be covered for the same benefits available to Team Members under age 65. In this case, your group benefits plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to disenroll completely from the plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the plan. In addition, HMMA is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

If you are age 65 or older, considering retirement, and think you may need to buy COBRA coverage after you retire, you should read the section below dealing with COBRA coverage - particularly the discussion under the heading "I Am Age 65 or Older and about to Retire. Can I Have Medicare and COBRA Coverage at the Same Time?"

Other Medicare Rules

Disabled Individuals: If you or your spouse is eligible for Medicare due to disability and is also covered under the plan by virtue of your current employment status with HMMA, Medicare will be considered the primary payer (and the plan will be secondary) if your group employs fewer than 100 Team Members. Because your group employs over 100 or more Team Members, the plan will be primary and Medicare will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of HMMA). Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact your group administrator for further information.

When Will Coverage Terminate?

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

1. the date on which the Team Member fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the leave of absence rules below);
2. for spouses, the date of divorce or other termination of marriage;
3. for children, the date a child ceases to be a dependent;
4. for the subscriber and his or her dependents, the date of the subscriber's death;
5. your group fails to pay us the amount due within 30 days after the day due;
6. upon discovery of fraud or intentional misrepresentation of a material fact by you or your group;
7. at any time your group fails to comply with the contribution or participation rules in the enrollment agreement;
8. when none of your group's members still live, reside or work in Alabama; or,

9. on 30 days advance written notice from your group to us.

In all cases the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other Team Members in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Will I Lose My Coverage During a Leave of Absence?

If HMMA is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to HMMAs who employ 50 or more Team Members. You should contact HMMA to determine whether leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an HMMA-approved leave of absence, including sick leave. Contact HMMA to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see HMMA for information about your rights to continue coverage under the plan.

COBRA COVERAGE

What Is COBRA? Does It Apply to Me?

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to continue coverage under the plan beyond the point at which coverage would otherwise end.

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year.

You must contact HMMA to determine whether this plan is covered by COBRA. Blue Cross is not your plan administrator.

COBRA coverage can be particularly important for several reasons. First, it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it. Second, it can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy pre-existing condition exclusion periods if they obtain health coverage elsewhere). And third, it could allow you to qualify for coverage under the Alabama Health Insurance Program (AHIP). See the discussion below under "What Happens When My COBRA Coverage Ends?" for more information about this. You do not have to demonstrate evidence of insurability in order to qualify for COBRA coverage.

You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes. If HMMA stops providing health care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact HMMA to determine if you have further rights under COBRA.

What Are My COBRA Rights if I Am a Covered Team Member?

If you are a covered Team Member and you would otherwise lose coverage under the plan because of your termination of employment or reduction in hours (except terminations for gross misconduct on your part), you may elect to buy COBRA coverage. Coverage will continue for up to 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, HMMA continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform HMMA that you do not intend to return to work, whichever occurs first.

You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

What Are My COBRA Rights if I Am a Covered Spouse or Child?

If you are covered under the plan as a spouse or dependent child of a covered Team Member, you may elect to buy COBRA coverage if you would otherwise lose coverage under the plan as a result of any of the following events:

- the covered Team Member's termination of employment or reduction in hours (except terminations for gross misconduct);
- the covered Team Member's death;
- the covered Team Member's divorce or legal separation from his or her spouse;
- the covered Team Member's enrollment in Medicare; or
- a covered child's loss of dependent status under the plan.

The period of COBRA coverage will be 18 months in the case of a termination of employment or reduction in hours and 36 months in the case of other qualifying events, provided that premiums are paid on time.

For spouses and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 18-month period. The 36-month period will run from the date of the termination of employment or reduction in hours.

Can COBRA Coverage be Extended if I Am Disabled?

Yes. In certain circumstances you can take advantage of a special disability extension.

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act during the first 60 days after the Team Member's termination of employment or reduction in hours, the 18-month period may be extended to 29 months or the date the disabled individual becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself.

In order for this disability extension to apply, you must notify the plan administrator of Social Security's determination within 60 days after the date of the determination and before the expiration of the 18-month period. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled individual elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. The 36-month period will run from the date of the termination of employment or reduction in hours.

Can I Add Newly Acquired Dependents to My COBRA Coverage?

Yes, but only under circumstances permitted under the health plan. In addition, except as explained below, any new dependents that you add to your coverage will not have independent COBRA rights. That means, for example, that if you die, they will not be able to continue coverage.

If you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension. The election should be made on the child's behalf by the child's legal guardian.

I Am Age 65 or Older and about to Retire. Can I Have Medicare and COBRA Coverage at the Same Time?

Yes, but there are a few things that you need to consider.

Most importantly, you should consider whether it is more beneficial to purchase a Medicare supplemental contract instead of COBRA coverage. After you retire, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Parts A or B of Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage after retirement will not cover most of your hospital and medical expenses. Call the benefits coordinator at HMMA for more information about this.

If you think you will need both Medicare and COBRA after your retirement, you should enroll in Medicare *on or before* the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your retirement. If you do not do this, your COBRA benefits will end when your Medicare coverage begins, and your covered dependents will have the opportunity to continue their own COBRA coverage for up to 36 months following the date of your retirement.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire.

Are There Notice and Election Rules That Apply to COBRA?

Yes.

You have the responsibility to inform the HMMA of a divorce, legal separation, or a child losing dependent status under the group health plan. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. *If this notice is not provided to HMMA, you will not be permitted to buy COBRA coverage as a result of divorce, legal separation, or a child losing dependent status.*

HMMA is responsible for (i) notifying you that you have the option to buy COBRA, and (ii), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (i) the date you would lose coverage under the plan, or (ii), the date on which HMMA notifies you that you have the option to buy COBRA coverage. An election to buy COBRA coverage will be considered made on the date sent back to HMMA.

Once HMMA has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

Can My COBRA Coverage Terminate Early?

Yes.

Your COBRA coverage will terminate early if any of the following events occurs:

- HMMA no longer provides group health coverage to any of its Team Members;
- you do not pay the premium for your continuation coverage on time;
- you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you;
- you become enrolled in Medicare after your COBRA qualifying event; or,
- you are covered under the 29-month disability extension and there has been a final determination that the disabled individual is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If you are buying COBRA coverage and you become covered under a group health plan that contains a pre-existing condition limitation or exclusion that *does* apply to you (for example, you do not have enough creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you), you should discuss the situation with the sponsor of the new plan (usually the new employer) to determine whether it makes sense nonetheless for you to

enroll in the new plan while continuing to pay for COBRA coverage at the same time. Since some plans limit the circumstances under which employees and their families may enroll, it is best to consult with the new employer concerning the interaction of COBRA and the new employer's group health coverage.

Can COBRA Benefits Change?

Yes, as and when benefits under the group health plan change.

By law, COBRA benefits are required to be the same as those made available to similarly situated active Team Members. If HMMA changes the group coverage, coverage will also change for you.

When Must COBRA Premiums be Paid?

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward.

There is a grace period of 30 days for all premium payments after the first payment.

Payment of your COBRA premiums is deemed made on the day sent.

What Happens When COBRA Coverage Ends?

If you exhaust your COBRA coverage you may buy a conversion health contract from Blue Cross. Please contact Blue Cross to determine whether a conversion contract is available. Conversion contracts have more limited coverage than COBRA coverage.

You may also qualify for coverage under state law. In Alabama, you can continue coverage through the Alabama Health Insurance Plan (AHIP). You can reach AHIP by calling the State Employees' Insurance Board in Montgomery, Alabama. In other states, you should call the state insurance department. If you elect to buy a conversion contract instead of enrolling in AHIP, you will not be able to enroll at a later date in AHIP.

By contrast, if COBRA coverage ends because you stop paying for it, then you will not have any further coverage under the group health plan and you will not be eligible to buy conversion coverage (if available) and you may not qualify for continued coverage under any applicable state law program. For example, in Alabama, you would not qualify for continued coverage under AHIP.

If you have any further questions about COBRA or **if you change marital status, or you or your spouse or child changes address, please contact Blue Cross.** Additional information about COBRA can also be found at the web site of the Pension and Welfare Benefits Administration of the United States Department of Labor.

CERTIFICATES OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a concept known as "creditable coverage." Your coverage under this plan is considered creditable coverage. If you have sufficient creditable coverage under this plan and you do not incur a break in coverage (63 continuous days of no creditable coverage), you may be able to reduce or eliminate the application of a pre-existing illness exclusion in another health plan. See the section of this summary dealing with pre-existing condition periods for an explanation of how this works.

At any time up to 24 months after the date on which your coverage ceases under the plan, you may request a copy of a certificate of creditable coverage. In order to request this certificate, you or someone on your behalf must call or write Customer Service.

BENEFIT CONDITIONS

To qualify as plan benefits, medical or dental services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;

2. We must determine before, during or after services and supplies are furnished that they are medically or dentally necessary;

3. PPO and Preferred Dentist benefits must be furnished while you are covered by this plan and the provider must be a PPO Provider or a Preferred Dentist when the services or supplies are furnished to you;

4. Separate and apart from the requirement in paragraph 3. above, services and supplies must be furnished by a provider (whether a Preferred Provider or not) who is recognized by us as an approved provider for the type of service or supply being furnished. For example, we reserve the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call Customer Service if you have any question whether your provider is recognized by us as an approved provider for the services or supplies you plan on receiving;

5. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

HEALTH BENEFITS

All benefits are subject to all deductibles, conditions, limitations and exclusions of the plan.

BEFORE YOUR HOSPITAL ADMISSION--CAUTION: One of several requirements for hospital benefits is that we certify the medical necessity of your hospital stay in advance, except for emergencies and when you are admitted to a Concurrent Utilization Review Hospital by a Preferred Medical Doctor. Emergency admissions require notice to us within 48 hours and must also be certified by us as both medically necessary and as an emergency admission. You may appeal these decisions. **Failure to obtain our certificate of medical necessity will result in no benefits being paid for your hospital stay or the admitting physician.** Just because we certify a hospital admission as medically necessary does NOT mean we have decided to pay benefits for it. For example, the admission may be for an excluded condition.

Inpatient Hospital Benefits in a PPO or Participating Hospital (in Alabama) or a PPO Hospital (Outside of Alabama)

1. Bed and board and general nursing care in a semiprivate room; **or**
2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them; **and**
3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
4. Administration of anesthetics by hospital employees and all necessary equipment and supplies;
5. Casts and splints, surgical dressings, treatment and dressing trays;
6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays;
7. Physical therapy, hydrotherapy, radiation therapy and chemotherapy;
8. Oxygen and equipment to administer it;
9. All drugs and medicines used by you and administered in the hospital;
10. Regular nursery care and diaper service for a newborn baby while its mother has coverage;
11. Blood transfusions administered by a hospital employee.

Inpatient Hospital Benefits for Maternity

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity.

Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama

Benefits are **$10** a day for room, board and nursing plus **75%** of the hospital's charges for all other services and supplies. Benefits are paid only in cases of accidental injuries.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

The only outpatient services for which we pay Non-Participating Hospitals in Alabama are for services to treat an accidental injury.

PPO (Preferred Provider Organization) Outpatient Facility Benefits

1. Emergency treatment of an accidental injury;
2. Chemotherapy and radiation therapy;
3. IV therapy;
4. Hemodialysis;
5. X-rays, lab and pathology services;
6. Medical emergency (subject to copay);
7. Surgery (subject to copay).

Preferred Home Health Care

1. Preferred Home Health Care benefits which are home IV therapy, intermittent home nursing visits by an R.N. or L.P.N. and home phototherapy for newborns. The services must be ordered by your physician and provided by a Preferred Home Health Care Provider. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1-800-821-7231.
2. Preferred Hospice benefits which are physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management. The services and supplies must be furnished by a Preferred Hospice to a member certified by his physician to have less than six months to live. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1-800-821-7231.

Note: Private Duty Nursing Services are not covered under Preferred Home Health Care.

PPO Physician Benefits

1. Surgery, which includes preoperative and postoperative care, reduction of fractures and endoscopic procedures;
2. Anesthesia by a PPO for a covered service;
3. Second surgical opinion services by a PPO;
4. Obstetrical care for childbirth, pregnancy, and the usual care before and after those services;
5. Inpatient visits by a PPO while you're a hospital patient for other than surgery, obstetrical care, or radiation therapy except for an unrelated condition;
6. Consultation for a medical, surgical or maternity condition by a specialty PPO but only one for each hospital stay;
7. Diagnostic lab, x-ray and pathology services in a PPO's office when related to covered services but not allergy testing;
8. Radiation therapy and chemotherapy by a PPO;
9. Care by a PPO in the emergency room of a hospital for other than surgery or maternity (subject to copay);
10. Exam, diagnosis, and treatment for an illness or injury besides routine office visits and allergy treatment in a PPO's office (subject to copay).

Your PPO physician or other Preferred or Participating Provider may bill another group health plan for any difference between the amount we pay and his charge for any service which is a benefit of this plan. For a PPO service provided by a Non-PPO Provider in the area where a PPO Provider is available, the allowed amount is the PPO Fee Amount Payable.

PPO Preventive Services

1. Routine immunizations to prevent diphtheria, tetanus, pertussis, polio, rubella, mumps, measles, Hib (meningitis, epiglottitis and joint infections), hepatitis B, chicken pox, and invasive pneumococcal disease in children during the first two years of life;

2. Inpatient visits by a PPO for routine newborn care;

3. One routine pap smear each calendar year for females;

4. One baseline mammogram for females ages 35-39; one mammogram a year for ages 40 and over; see Mastectomy and Mammograms (later in this booklet) for additional information;

5. One prostate specific antigen test each year for males ages 40 and over;

6. One PPO office visit a year when combined with a routine pap smear, mammogram or prostate screening (subject to copay);

7. Nine office visits for the first two years of a baby's life; annual exams for ages two through six (subject to copay).

Prepaid Prescription Drug Benefits

1. To be eligible for benefits, drugs must be legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal Law prohibits dispensing without a prescription." Compound drugs are covered if at least one of the drugs in the compound is a legend drug. In some cases, drugs may also require prior authorization. Your Participating Pharmacist will advise if this is a requirement.

2. Drugs can be dispensed in a maximum of a 30-day supply for each drug or refill. Refills are allowed only after 60% of the previous prescription has been used, e.g., 18 days into a 30-day supply.

3. Maintenance drugs (including certain diabetic supplies) can be dispensed in the greater of a 60-day supply or 100 unit doses (a copay will be taken for each 30-day supply). Participating Pharmacies should have a list of maintenance drugs.

4. Insulin, needles and syringes purchased on the same day for the same days supply will have one copay; otherwise, each has a separate copay. Blood glucose strips and lancets purchased on the same day for the same days supply will have one copay; otherwise, each has a separate copay. Glucose monitors always have a separate copay. The copay that applies depends on whether the monitor or supplies are generic, Preferred Brand, or Non-Preferred Brand, as set out in the Prescription Drugs section in the Summary of Health Benefits. These are the only diabetic supplies available through the Prepaid Prescription Drug program.

Baby Yourself Program

If you or your spouse is pregnant, Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 733-7065 in Birmingham) as soon as you find out you are pregnant Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant. If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse:

- ages 35 or older
- high blood pressure
- diabetes
- history of previous premature births
- multiple births (twins, triplets, etc.)

Other Covered Services

1. Semiprivate room and board, general nursing care, and all necessary hospital services and supplies when your inpatient hospital benefits are all used.
2. Outpatient hospital services.
3. Anesthesia for surgery or obstetrical care when given by other than the surgeon, obstetrician or hospital employee.
4. Physical therapy and hydrotherapy given by a licensed physical therapist. Preferred Physical Therapists may be required to precertify services during the course of your treatment. If so, the Preferred Physical Therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.
5. Radiation therapy and chemotherapy.
6. Lab and x-ray exams and other diagnostic tests such as allergy testing.
7. Artificial arms and other prosthetics; leg braces and other orthopedic devices.
8. Medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints.
9. Treatment of natural teeth injured by a force outside your mouth or body, if service is received within 90 days of the injury.
10. Professional ambulance service to the closest hospital that could treat the condition.
11. The less expensive for rental or purchase of durable medical equipment such as wheelchairs and hospital beds.
12. Hemodialysis services of a Participating Renal Dialysis Facility.
13. Treatment of mental and nervous disorders including alcoholism and drug addiction.

14 Physician's covered services. Surgery includes preoperative and postoperative care, reduction of fractures and endoscopic procedures, maternity deliveries and heart catheterization. The Allowed Amount and PPO fees for surgical care follow these rules:

a. If two or more related surgical procedures are done in the same sessions, we allow for only the procedure with the largest fee. If the procedures are not related but done during the same session, we allow the full amount for the procedure with the largest fee and one-half of the fee for each of the others.

b. For delivery of twins, triplets, etc., we allow the one largest fee, whatever the number of babies or how they are delivered.

c. When two different specialists assist each other to operate in the same field as co-surgeons, we allow each 75% of the fee for the surgery. We won't allow them more for assisting at surgery, as they assisted each other.

15. Occupational therapy services when the following conditions are met:

a. The services must be medically necessary and performed by a licensed occupational therapist.

b. The services must be related to the hand and/or treatment of lymphedema, and must be of a type that we cover under our occupational therapy program. Call Customer Service at the number on the back cover to determine what specific diagnostic codes and procedures are covered.

If you see a Preferred Occupational Therapist, the therapist will bill us and we will pay him or her directly. By contrast, if you see an occupational therapist who is not a Preferred Occupational Therapist, you may have to file your claim, and we will pay you directly.

Preferred Occupational Therapists may be required to precertify services during the course of your treatment. If so, the Preferred Occupational Therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

16. Phase I therapy and exams for TMJ disorders according to the guides of the American Academy of Craniomandibular Disorders.

17. Chiropractic services.

Expanded Benefits for Psychiatric Services (EPS)

1. 30 days of inpatient care a year for mental and nervous disorders, chemical detoxification and rehabilitation;
2. Outpatient visits;
3. Individual, group and family therapy or counseling;
4. Psychological tests;
5. Lab tests;
6. Services by professional staff members such as psychologists and social workers trained in mental health and chemical dependency.

Exclusions for EPS:

1. Speech therapy;

2. Diagnosis or treatment of mental retardation;
3. Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;
4. Any treatment not recommended by the EPS provider, even if court ordered;
5. Treatment for chronic pain or solely for obesity;
6. Services related to narcotic maintenance therapy such as methadone maintenance therapy;
7. Services related to nicotine addiction;
8. Sex therapy programs or treatment for sex offenders;
9. Prescription drugs;
10. Residential psychiatric facilities.

Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may assist you in accessing the most appropriate health care for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to you and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through Individual Case Management are subject to your benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Health Management division at (205)733-7067 or 1-800-821-7231.

If you suffer from certain long-term, chronic, diseases or conditions you may qualify to participate in the Care Management Program. Care Management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the Care Management Program determines from your claims data that you are a good candidate for Care Management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call Customer Service at the number on the back cover.

Organ, Tissue and Bone Marrow/Cell Transplants

The organs and tissue for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. The transplant must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and the transporting the organ and removal team.

There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) recipient or donor room, food, or transportation costs we did not approve in writing; (7) a condition or disease for which a transplant is considered investigational; (8) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance

Vision Care Benefits

Routine service benefits are provided and include the following services:

1. Vision exam;
2. Glasses;
3. Frame;
4. Contact lenses.

See the Summary of Health Benefits for limitations, deductible, and copays.

Exclusions for Vision Care Benefits:

1. Diagnostic services;
2. Benefits provided after the member's coverage under this contract ends except covered lenses or frames prescribed and ordered before and delivered within 60 days from then;
3. Orthoptics, vision training, and low vision aids;
4. Replacement of lost or broken lenses or frames unless at the time of replacement the member is eligible for benefits;
5. Services or supplies required by the group as a condition of employment or rendered by a medical department or health clinic maintained by or on behalf of the group, a mutual benefit association, labor union, trustee, or similar person or entity.

Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefits for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- If you are at high risk of developing breast cancer or you have a family history of breast cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure

according to the benefit provisions of the plan dealing with diagnostic x-rays.

- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

COORDINATION OF BENEFITS (COB)

Plan benefits aren't payable to the amount they are provided by another group plan or if another plan is the "primary" plan. Which plan is primary is decided by the first rule below that applies:

1. If the other plan has no COB provision, it is primary.
2. Team Member/Dependent: The plan covering the patient as an Team Member is primary over the plan covering the patient as a dependent.
3. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If both plans don't use this "birthday rule" the other plan's rule will be used.
4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:

   a. first, the plan of the parent with custody;

   b. then, the plan of the spouse of the parent with custody;

   c. last, the plan of the parent without custody.

   If there is a court order that specifically states that one parent must provide the child's health expenses, that parent's plan is primary.
5. Active/Inactive Team Member or Dependent: The plan covering a person as an active Team Member is primary over a plan covering the person as laid off or retired.
6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If this plan is secondary, it will not pay more than if it had been primary.

SUBROGATION

Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we've paid plan benefits. This means that you promise to repay us from any money you recover the amount we've paid or provided in plan benefits It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you aren't made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

CLAIMS AND APPEALS

The following explains the rules under your group health/dental plan for filing claims and appeals.

Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to handle without an appeal. The phone number to reach our Customer Service Department is on the back of this booklet.

In General

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, we will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling our Customer Service Department. You can also go to our Internet web site at www.bcbsal.com and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

Post-Service Claims

What Constitutes a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is medical records that we may need in order to determine whether services or supplies were medically necessary. If we need this sort of additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Who Gets Paid: Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this

completes our obligation to you under the plan. We need not honor an assignment of your claim to anyone. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain precertification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might precertify your inpatient hospital admission but later deny your claim because the admission related to a pre-existing condition or was for a service or supply that is excluded under the plan.

In order to file a pre-service claim you or your provider must call our Health Management Department at 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from a Participating Chiropractor, Preferred Physical Therapist, or Preferred Occupational Therapist, your provider is responsible for initiating the precertification process for you. For home health care and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (i) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (ii), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

Non-Urgent Pre-Service Claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy Pre-Determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

Concurrent Care Determinations

Determinations by us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write our Customer Service Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Your satisfaction is important to us. We will do our utmost to maintain it.

Appeals

In General: The rules in this section of the booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- our denial of a pre-service claim; or,
- an adverse concurrent care determination (for example, we deny your request to extend previously approved care).

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet web site at www.bcbsal.com. Once there, you may ask us to send a copy of the form to you.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;

- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,

- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

  Blue Cross Blue Shield of Alabama
  Attention: Health Management - Appeals
  P. O. Box 2504
  Birmingham, Alabama 35201-2504

  and

- For Preferred Physical Therapy, Occupational Therapy, or care from a Participating Chiropractor (when covered by your plan):

  Blue Cross Blue Shield of Alabama
  Attention: Health Management - Appeals
  P. O. Box 362025
  Birmingham, Alabama 35236

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct Of The Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a health care professional who has appropriate expertise. If we consulted a health care professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

We will consider your appeal fully and fairly.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- you may ask our Customer Service Department for further help;
- you may file a voluntary appeal (discussed below); or,
- you may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

HMMA has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of administrative services under the plan. Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so. Mail notices to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858, with your full name and contract number. We get notice when it arrives at this address.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your Claim Report.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. If your group materially misrepresents its application it will be as though the plan never took effect, and we need not even refund any payment for any member.

Respecting Your Privacy

To administer this plan we need your medical information from physicians, hospitals, dentists and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from health or dental care providers and other plan administrators. By applying for coverage and participating in this plan, you authorize us to obtain, use and release all records about you and your minor dependents that we need in order to administer this plan. If you or any provider refuse to provide records, information or evidence we request within reason, we may deny any more payments to the one refusing. We will strive to keep this information confidential and release it only to others who have a legitimate need for the information. We will not be liable for uses of the information which we have not authorized.

Multiple Coverage

If you are covered both by this contract and by a non-group contract we issue, you will be entitled to benefits only under the one that provides the most coverage for you.

Applicable Law

The federal ERISA law governs this plan. If any state law applies, the law of Alabama governs.

Plan Terminations

1. The plan may be terminated at any time by either the group or Blue Cross by giving 30 days notice in writing to the other.

2. The plan may be terminated by Blue Cross immediately by notice in writing to the group when the group has other group health or dental coverage.

3. If the group fails to pay the amount due within 30 days after it becomes due, the plan will terminate automatically and without notice to you or the group as of the date due for the payment.

Plan Changes

1. By giving 30 days notice in writing to the group, we may change the amount of the payment for coverage or change, add, or remove any other provisions in the plan or in your coverage without sending individual notices to you only. The group solely is responsible for notifying you of the change. The change will be effective whether or not the group notified you of the change, and we are not responsible for any failure to do so.

   The notice of change will state the effective date of the change. The change will apply to all benefits for services you receive on or after the stated effective date. If the group submits payment for coverage to us after a notice of changes, it will be considered acceptance by you and the group of the new payment amount or other plan changes.

2. By written agreement between the group and Blue Cross, signed by Blue Cross's officer, the plan and any of its provisions and coverage may be changed, removed, or added without sending individual notices to you.

3. The plan can be changed only through changes made in writing and signed by Blue Cross's officer in the manner stated above. None of Blue Cross's representatives, officers, employees, or agents can make any contract changes orally, as by telephone, or in any other way except in writing as described above.

Out-of-Area Co-Pay and Co-Insurance

When you obtain health care services through the BlueCard Program outside of the Alabama service area, the amount you pay for covered services is calculated on the **lower** of:

1. The billed charges for your covered services, or

2. The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Plan") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

HEALTH BENEFIT EXCLUSIONS

We **will not** provide benefits for the following:

1. Services or expenses we determine are not medically necessary.

2. Services, care, or treatment you receive during any period of time that we have not been paid for your coverage and that nonpayment results in plan termination.

3. Services, care, or treatment you receive after the date your coverage ends. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

4. Services or expenses for cosmetic surgery. "Cosmetic surgery" is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Women's Health and Cancer Rights Act, for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

   a. Please contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual fields measures and photographs before and after surgery.

   b. Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's

Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and many sinus infections. To correct this they have a septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance but reconstructive if done because your eyelids kept you from seeing very well.

5. Services or expenses to care for, treat, fill, extract, remove or replace teeth or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw. This does not apply to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

6. Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.

7. Services or expenses in cases covered in whole or in part by workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for hospital or medical services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

8. Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provides or pays for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

9. Services or supplies to the extent that a member is, or would be, entitled to reimbursement under Medicare, regardless of whether the member properly and timely applied for, or submitted claims to, Medicare, except as otherwise required by federal law.

10. Routine well child care and routine immunizations except as provided in PPO benefits.

11. Routine physical examinations except as provided in PPO benefits.

12. Services or expenses for custodial care. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

13. Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.

14. Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except mycotic nails).

15. Hospital admissions in whole or in part when the patient primarily receives services to rehabilitate such as physical therapy, speech therapy, or occupational therapy.

16. Services and expenses provided to a hospital patient which could have been provided on an outpatient basis, given the patient's condition and the services provided. Benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy.

17. Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease or which are related to surgical sex transformations.

18. Services for or related to pregnancy, including the six-week period after delivery, of any dependent other than the Team Member's wife.

19. Services or expenses for an accident or illness resulting from war, or any act of war, declared or undeclared, or from riot or civil commotion.

20. Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution.

21. Services or expenses for which a claim is not properly submitted to Blue Cross.

22. Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of the Claims Administrator. Benefits will only be provided for one surgical procedure for obesity (morbid) in a lifetime. Benefits will not be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure.

23. Services or expenses which you are not legally obligated to pay, or for which no charge would be made if you had no health coverage.

24. Services or expenses for or related to organ, tissue or cell transplantations except specifically as allowed by this plan.

25. Dental treatment for or related to temporomandibular joint (TMJ) disorders. This includes Phase II, according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth or a combination of these treatments.

26. Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

27. Eyeglasses or contact lenses or related examination or fittings. (But, one pair of eyeglasses or one pair of contact lenses or one pair of each will be covered under Other Covered Services if medically necessary to replace the human lens function as a result of surgery in the eye or eye injury or defect.) This does not apply to Vision Care Benefits.

28. Services or expenses for eye exercises or visual training except under the Vision Care Benefits.

29. Orthoptics, orthokeratology, or refractive keratoplasty (which includes radial keratotomy).

30. Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

31. Services or expenses for speech, recreational, educational, or occupational (except as stated covered previously) therapy.

32. Services or expenses for acupuncture, biofeedback and other forms of self-care or self-help training.

33. Hearing aids or examinations or fittings for them.

34. Services or expenses of a hospital stay, except one for an emergency, unless we certify it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

35. Services or expenses of private duty nurses.

36. Services provided by Psychiatric Specialty Hospitals which do not participate with nor are considered members of any Blue Cross and/or Blue Shield Plan.

37. Services, care, treatment, or supplies furnished by a provider that is not recognized by us as an approved provider for the services rendered as explained more fully in paragraph 4. under the section of this summary called "Benefit Conditions."

38. Services or expenses any provider rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physical therapist.

39. Services provided by Substance Abuse Facilities including Substance Abuse Residential Facilities.

40. Services and expenses rendered by a Non-Preferred Home Health Care or Non-Preferred Hospice provider in Alabama.

41. Services or expenses of any kind for nicotine addiction such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist.

42. Travel, even if prescribed by your physician.

43. Inpatient care or treatment for mental and nervous disorders or disease (including alcoholism and drug addiction) is covered under Expanded Benefits for Psychiatric Services, but is not covered under Other Covered Services after the basic hospital days have been used.

44. Services or expenses of any kind provided by a Non-Participating Hospital located in Alabama for any benefits under this plan, except for inpatient and outpatient hospital benefits in case of accidental injury, as more fully described under "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits."

45. Services or expenses for a claim we have not received within 24 months after services were rendered or expenses incurred.

46. Services or expenses for physical therapy which does not require a licensed physical therapist, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency or duration

47. Services or expenses in any federal hospital or facility except as provided by federal law.

48. Services or expenses for sanitarium care, convalescent care, or rest care.

49. Anesthesia services or supplies, or both, by local infiltration.

50. Services provided through teleconsultation.

51. Services provided by a Non-Participating Renal Dialysis Facility in Alabama.

DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident.

Allowable Amount: The lesser of the fee for a procedure in the Preferred Dentist Fee Schedule or the amount charged by a dentist, other than an out-of-state dentist. For an out-of-state dentist "Allowable Amount" means UCR.

Allowed Amount: The amount of a provider's charge that any Blue Cross Plan recognizes for payment for plan benefits. This is based on the payment method used by the Blue Cross and/or Blue Shield Plan where services are received. In Alabama, payment for covered services is based on the usual, customary and reasonable (UCR) fee or the Fee Schedule that would otherwise be paid to a Preferred Provider furnishing the same services or supplies, as determined by us.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care," "Individual Case Management," and "Care Management."

Application: The subscriber's original application form and any written supplemental application we accept.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

Blue Cross: Blue Cross and Blue Shield of Alabama.

BlueCard Program: An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Certification of Medical Necessity: The written results of our review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours or the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not mean that your group has paid us all monies due for you. Certification of medical necessity does not consider whether your admission is excluded by this plan.

Charge: The reasonable charge not exceeding the provider's actual charge regularly and customarily made for those services or supplies. For services or supplies furnished to a member by a Preferred Provider, "charge" means the amount for those services or supplies which Blue Cross has agreed upon with the Preferred Provider. In the case of services or supplies for which a usual, customary and reasonable fee exists (other than a Preferred Provider) the charge will be the Allowed Amount.

Concurrent Utilization Review Program (CURP): A program designed to promote the most efficient and effective use of health care resources while utilizing cost-effective methods to administer benefits.

Contract: The Group Health and Dental Benefits contract between HMMA and Blue Cross and Blue Shield of Alabama. The contract is made up of (1) HMMA's Group Application for the contract; (2) this Summary Plan Description; and (3) any written change to this Summary Plan Description. Your contract number is listed on your ID card.

Contract Effective Date: The date the Group Health and Dental Benefits contract becomes effective; the same date we accept the Group Application.

Cosmetic Surgery: Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect. For important information on cosmetic surgery, see the "Exclusions" section.

Covered Dental Benefits: The amount of benefits we pay to or for you for dental services by a dentist which you incur while covered under this plan.

Custodial Care: Care primarily to provide room and board for a person who is mentally or physically disabled.

Dentist: One of the following when licensed and when acting within the scope of his license at the time and place where the service is rendered: Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

Dependent: See the explanation in the "Eligibility and Enrollment" section.

Durable Medical Equipment: Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

Effective Date: The date on which the coverage of each individual subscriber and dependent begins as listed in Blue Cross's records.

Eligible Person: Any Team Member or member of the group or other person who meets the eligibility standards of their plan and is designated as eligible to us by the group.

Family Coverage: Coverage for a subscriber and one or more dependents.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Group: HMMA, association, or other entity which contracts with Blue Cross and through which you have coverage.

Group Application: The document in which HMMA applies to us for a group benefits plan.

Home Health Care Agency: A Preferred or a Non-Preferred Home Health Care Agency.

Hospice: A Preferred or a Non-Preferred Hospice.

Hospital: A Participating or a Non-Participating Hospital as defined in this plan.

Individual Case Management: Benefits which are an alternative to more expensive covered benefits. They provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care" and "Care Management."

Inpatient: A registered bed patient in a hospital.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by attending physician and other medical providers.

Medical Emergency: A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

Medically or Dentally Necessary or Medical or Dental Necessity: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical or dental criteria) that we use to determine medical or dental necessity We base these criteria on peer-reviewed literature, recognized standards of medical or dental practice, and technology assessments. We put these medical and dental criteria in policies that we make available to the medical and dental community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically or dentally necessary according to one of our published medical or dental criteria policies, we will not pay for it. If a service or supply is not addressed by one of our published medical or dental criteria policies, we will consider it to be medically or dentally necessary only if we determine that it is:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your medical or dental condition;
- provided for the diagnosis or direct care and treatment of your medical or dental condition;
- in accordance with standards of good medical or dental practice accepted by the organized medical or dental community;
- not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- not "investigational;" and,
- in cases of medical care, performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically or dentally necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical or dental necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical or dental service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical or dental providers.

Member: A subscriber or eligible dependent who has coverage under the contract The term member also refers to a former dependent or subscriber who was not terminated for gross misconduct and who is eligible for and covered under COBRA.

Mental and Nervous Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental and nervous disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental and nervous disorders however they are caused, based or brought on. Mental and nervous disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy which is not a Participating Pharmacy.

Non-PPO Provider: Any provider which is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Brand: Any brand name drug that is not a Preferred Brand.

Non-Preferred Dentist: A dentist licensed to practice dentistry in Alabama who is not a Preferred Dentist.

Non-Preferred Home Health Care Agency: Any home health care agency which is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice which is not a Preferred Hospice.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

PPO Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

PPO Hospital, PPO Physician, PPO Provider, or Preferred Provider: Any hospital, physician, or provider with which any Blue Cross and/or Blue Shield Plan has a PPO contract for the furnishing of health care services.

Participating Ambulatory Surgical Facility: Any facility with which Blue Cross and Blue Shield of Alabama has a Participating Ambulatory Surgical Facility contract for furnishing health care services.

Participating Hospital: Any hospital with which Blue Cross and/or Blue Shield Plan has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which Blue Cross or its subsidiary, Preferred Care Services, Inc., has a contract for dispensing prescription drugs.

Participating Psychiatric Provider: Any provider of psychiatric services with which Blue Cross has a contract for furnishing mental health and chemical dependency services.

Participating Renal Dialysis Facility: Any freestanding hemodialysis facility with which Blue Cross and Blue Shield of Alabama has a contract for furnishing health care services.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologists who are licensed by the state in which they practice (Ph.D., Psy.D or Ed.D.), as defined in Section 27-1-18 of the Alabama Code.

Plan: This Summary Plan Description (SPD) describing the benefits of your Team Member's Health and Dental Benefits Plan.

Preadmission Certification and Postadmission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or within 48 hours or the next business day after the admission in the case of an emergency admission, based upon medically recognized criteria.

Preferred Brand: Brand name drugs that combine effectiveness and cost efficiency, as determined by an expert group of physicians and pharmacists serving on the Blue Cross and Blue Shield of Alabama Pharmacy and Therapeutics Committee.

Preferred Care: A program whereby providers have agreements with Blue Cross to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, certain services and supplies to members entitled to benefits under the Preferred Care Program.

Preferred Dentist: A dentist who has an agreement with Blue Cross to provide dental services to members entitled to benefits under the Preferred Dentist Program.

Preferred Dentist Fee Schedule: The schedule of dental procedures and the fee amounts for those dental procedures under the Preferred Dentist Program.

Preferred Dentist Program: A program wherein some dentists have agreements with Blue Cross to furnish certain services for an agreed upon fee schedule to members entitled to benefits under the Preferred Dentist Program.

Preferred Home Health Care Agency: Any home health care agency inside or outside of Alabama with which Blue Cross has a contract.

Preferred Home Health Care Fee Schedule: The schedule of procedures and the fee amounts listed in the Preferred Home Health Care Fee Schedule or the amount of the Preferred provider's actual charge, whichever is less for Preferred Home Health Care Benefits.

Preferred Hospice: Any hospice inside or outside of Alabama with which Blue Cross has a contract.

Preferred Medical Doctor or Preferred Physician: A physician who has an agreement with Blue Cross to provide surgical and medical services to members entitled to benefits under the PPO Program or another Preferred Care Program through a contract with Blue Cross.

Preferred Provider Organization (PPO): Hospitals, physicians, or other providers who have agreements with any Blue Cross and Blue Shield Plan to provide surgical and medical services to members entitled to plan benefits under the PPO Program.

Preferred Radiology Provider or PRP: Any provider with which Blue Cross and Blue Shield of Alabama has a contract for the furnishing of diagnostic radiology procedures such as computerized axial tomography (CAT scan) and magnetic resonance imaging (MRI scan).

Pregnancy: The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body-usually, but not always, in the uterus-and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Private Duty Nursing: Nursing care provided in the patient's home by a licensed professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who does not reside in the patient's home and is not related to the patient by blood or marriage.

Radiology Schedule: The schedule of radiological procedures which is on file and available for examination at the Birmingham offices of Blue Cross.

Subscriber: The Team Member whose application for coverage under the contract is made and accepted by Blue Cross.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

UCR (Usual, Customary and Reasonable Fee): That part of a provider's charge that we will allow as covered expenses. The usual, customary and reasonable value of the provider's service is based on historical data developed from the following criteria:

- how much he charges his patients for the same or a similar service;
- the variance in the charges by most providers for the same service in the same geographic area, if possible;
- whether the procedure requires more time, skill, or experience than it usually requires;
- the value of the procedure compared to other services;
- whether the UCR fee exceeds the PPO fee for the same services;
- out-of-state adjustments to account for the way providers charge in other states;
- the rate of inflation using any generally recognized measure. This may cap any increase in the PPO fee.

The UCR allowance will not exceed the amount the provider charges.

For dental, the UCR fee is the amount of a dentist's charge that Blue Cross will recognize as covered expenses for medically/dentally necessary services provided by this plan, if services are provided by a dentist who is not licensed to practice in Alabama.

We, Us, Our: Blue Cross and Blue Shield of Alabama.

You, Your: The subscriber or member as shown by context.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health and Dental Plan Coverage

Continue health and dental care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health and dental plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health and dental plan or health and dental insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Team Member benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including HMMA, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your

rights, you may seek assistance from the U S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Administrative Information

The following information is provided to complete the requirements for making this a Summary Plan Description as outlined in the Employee Retirement Income Security Act.

1. The Plan's official name is: Hyundai Motor Manufacturing Alabama, LLC Health and Welfare Plans

2. The Plan Sponsor and Plan Administrator is:

   Hyundai Motor Manufacturing Alabama, LLC
   7515 Halcyon Summit Drive
   Montgomery, Alabama 36117

   Hyundai Motor Manufacturing Alabama, LLC is responsible for discharging all obligations that ERISA and its regulations impose upon Plan Sponsors and Plan Administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law. To the extent not delegated to Blue Cross, Hyundai Motor Manufacturing Alabama, LLC, as plan sponsor, has the discretionary authority to interpret and construe the terms of the plan.

3. The Plan Number assigned by the Plan Sponsor is: 501

4. The IRS Employer Identification Number (EIN) of the Sponsor is: 37-1426698

5. The Plan provides hospital, medical, and dental benefits as administered under a contract by Blue Cross and Blue Shield of Alabama under group number 48584. Blue Cross has complete discretion to interpret and administer the provisions of the Plan. Its administrative functions include paying claims, determining medical and dental necessity, etc. The address of Blue Cross and Blue Shield of Alabama is 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. The plan benefits are underwritten.

6. The Agent for legal process is:

   Hyundai Motor Manufacturing Alabama, LLC
   7515 Halcyon Summit Drive
   Montgomery, Alabama 36117

7. The records of the health and dental plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.

8. Hyundai Motor Manufacturing Alabama, LLC currently intends to continue the Group Health and Dental Care Plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active Team Members, retirees, former Team Members, and all dependents.

9. This is an HMMA-Team Member Shared Cost Plan. The sources of the contributions to this Plan are currently HMMA and the Team Member in relative amounts as determined by HMMA from time to time. While HMMA may change its level of contribution at any time, HMMA must always contribute at least a portion of the Team Member's premiums. Any information concerning what is to be paid by the Team Member in the future will be furnished by HMMA in writing and will constitute a part of this Plan. Your contribution is determined by HMMA based on the plan's experience and other factors.

SUMMARY OF DENTAL BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

Maximum Benefit Amounts*	Deductible**
$1,500 per member each calendar year	$25 per member each calendar year ($50 per family) (does not apply to diagnostic and preventive services)

* Charges applied toward annual and/or lifetime maximums incurred by you or your covered dependents while covered under another Blue Cross and Blue Shield of Alabama contract will be applied toward annual and/or lifetime maximums under this contract.

** The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum deductible has been met, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year.

We pay benefits toward the lesser of the Preferred Dentist Fee Schedule or the dentist's actual charge for services. This is the same amount whether you receive services from a Preferred or a Non-Preferred Dentist. There are three differences:

1. All Preferred Dentists agree our payment is payment in full except for your deductible and copayments. If you are covered under another group dental plan; a Preferred Dentist may bill that plan for any difference between the fee schedule amount and his usual charge for a service.

2. Non-Preferred Dentists may charge you the difference between what we pay and their billed amount.

3. Preferred Dentists may not collect their fee for plan benefits from you except for deductibles and copays. They must bill us first except for services which are not plan benefits, such as implants

Benefit	Copay
Basic - Diagnostic and Preventive Services	No copay
Basic - Restorative	20%
Supplemental Services	20%
Prosthetic Services	50%
Periodontic Services	50%

ORTHODONTIC BENEFITS

Benefit	Maximum Benefit Amounts	Deductible	Copay
Orthodontic Services	$1,500 per member in a lifetime	Subject to the same deductible as other dental services	50%

DENTAL BENEFITS

Payment of Benefits

We pay Preferred Dentists direct and pay you for services of Non-Preferred Dentists.

Basic Services

Diagnostic and Preventive Services

1. Dental exams, up to twice per calendar year.
2. Dental x-ray exams:
   a. Full mouth x-rays, one set during any 36 months in a row;
   b. Bitewing x-rays, up to twice per calendar year; and
   c. Other dental x-rays, used to diagnose a specific condition.
3. Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of **$20 per tooth** and limited to the first permanent molars of children through age 13.
4. Fluoride treatment for children through age 18, twice per calendar year.
5. Routine cleanings, twice per calendar year.
6. Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

Restorative Services

1. Fillings made of silver amalgam and tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 6-11 and 22-27; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
2. Simple tooth extractions.
3. Direct pulp capping, removal of pulp, and root canal treatment.
4. Repairs to removable dentures.
5. Emergency treatment for pain.

Supplemental Services

1. Oral surgery, i.e., to treat fractures and dislocations of the jaw, to diagnose and treat mouth cysts and abscesses and for tooth extractions and impacted teeth.
2. General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
3. Treatment of the root tip of the tooth including its removal.

Prosthetic Services

1 Full or partial dentures.

2. Fixed or removable bridges.

3 Inlays, onlays, veneers, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.

Limits on prosthetic services:

1 Partial Dentures - If a removable partial denture can restore the upper or lower dental arch satisfactorily, we will pay as though it were supplied even if you chose a more expensive means.

2 Precision Attachments - There are no benefits for precision attachments.

3. Dentures - We pay only toward standard dentures.

4 Replacement of Existing Dentures, Fixed Bridgework, Veneers, or Crowns - We pay toward replacing an existing denture, fixed bridgework, veneer, or crown only if the old one can't be fixed. If one can be fixed, we will pay toward fixing it (this includes repairs to fixed dentures). We only pay to replace these items every five years.

5. There are no benefits to replace lost or stolen items.

Periodontic Services

1. Periodontic exams twice each 12 months.

2. Removal of diseased gum tissue and reconstructing gums.

3. Removal of diseased bone.

4. Reconstruction of gums and mucous membranes by surgery.

5. Removing plaque and calculus below the gum line for periodontal disease.

Orthodontic Services

Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment for dependent children up to age 19 (age 25 if full-time student).

Exclusions and Limitations on Orthodontic Benefits:

1. The benefits for orthodontic services shall be paid only for months that you have orthodontic coverage. There are no benefits for orthodontic services to you before your coverage by this contract is in effect. If you started orthodontic services before this coverage began and complete them while covered, we'll prorate the benefits for the services you actually get while covered.

2. Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

DENTAL BENEFIT CONDITIONS

To qualify as plan benefits, dental services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;
2. We must determine before, during or after services and supplies are furnished that they are dentally necessary;
3. Preferred Dentist benefits must be furnished while you're covered by this plan and the physician must have a Preferred Dentist contract with us;
4. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

1. Examination and diagnosis no more than twice during any calendar year.
2. Full mouth x-rays will be provided once each 36 months. Bitewings no more than twice during any calendar year.
3. Routine cleaning will be provided no more than twice during any calendar year.
4. Fluoride treatment will be provided to members through age 18 no more than twice during any calendar year.
5. Tooth sealants on teeth numbers 3, 14, 19 and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of **$20 per tooth** and limited to the first permanent molars of children through age 13.
6. If you change dentists while being treated, or if two or more dentists do one procedure, we'll pay no more than if one dentist did all the work.
7. When there are two ways to treat you and both are plan benefits, we'll pay toward the less expensive one. The dentist may charge you for any excess.
8. Prosthetic - Gold, baked porcelain restorations, veneers, crowns and jaskets. If a tooth can be restored with a material such as amalgam, we'll pay toward that procedure even if a more expensive means is used.
9. Prosthetic - Payment will be made toward eliminating oral disease and replacing missing teeth.

GENERAL INFORMATION

Filing A Dental Claim

For you to obtain benefits we must receive a properly filed claim from you or your provider Most providers file for you. If your services are provided outside of Alabama you may have to file the claim yourself. Simply call our Customer Service Department at the number on the back cover of this plan booklet and ask for the claim form you need Then fill it out, attach an itemized bill and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

If the claim does not have all the information on it we need, we will not consider it but will return it, noting what is lacking. When we do get all the information we will see if the claim meets plan requirements. We will send the submitter a written decision as to the amount paid and, if any part is denied, the reason for denial. If we need more information, we'll tell you what we need. You agree that any decision we make in administering the plan which is not arbitrary and capricious will be final. All these decisions are subject to review.

Treatment Plan

A Treatment Plan is so your dentist knows whether certain dental treatments are plan benefits. Your dentist should have us review one for crowns, including inlays and onlays, and bridges. Your dentist should file the Treatment Plan. Have your dentist submit the recommended Treatment Plan and fees along with appropriate records and diagnostic x-rays or periodontal charting to us. We will notify your dentist of our determination on the proposed treatment.

DENTAL BENEFIT EXCLUSIONS

We will **not** provide benefits for the following:

1. Dental services you receive from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.
2. Dental services for which you are not charged.
3. Dental services or expenses in cases covered in whole or in part by workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for dental services as such. Finally, it applies whether HMMA has insurance coverage for benefits under the law.
4. Dental services with respect to malformations from birth or primarily for appearance.
5. Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provide or pay for care, through insurance or any other means. This applies even if the law does not cover all your expenses.
6. Dental services to the extent coverage is available to the member under any other Blue Cross and Blue Shield contract.
7. Charges for dental care or treatment by a person other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist
8. Gold foil restorations.

9. Charges for your failure to keep a scheduled visit with the dentist.

10. Services or expenses of any kind, if not required by a dentist, or if not dentally necessary.

11. Charges for oral hygiene and dietary information.

12. Charges for plaque control program.

13. Charges for implants.

14. Anesthetic services performed by and billed for by a dentist other than the attending dentist or his assistant.

15. Dental services you receive before your effective date of coverage, or after your effective date of termination.

16. Dental care or treatment not specifically identified as a covered dental expense.

17. Appliances or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth, and restoration from the malalignment of teeth. This does not apply to covered orthodontic services.

18. Charges to use any facility such as a hospital in which dental services are rendered, whether the use of such a facility was dentally necessary.

19. Services of a dentist rendered to a member who is related to the dentist by blood or marriage or who regularly resides in the dentist's household.

20. Services or expenses of any kind either (a) for which a claim submitted for a member in the form prescribed by Blue Cross has not been received by Blue Cross, or (b) for which a claim is received by Blue Cross later than 24 months after the date services were performed.

21. Any dental treatment or procedure, drugs, drug usage, equipment, or supplies which are investigational, including services that are part of a clinical trial.

22. Services or expenses for which a claim is not properly submitted.

23. Charges for infection control.

24. Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents.

25. Services or expenses of any kind for complications resulting from services received that are not covered as benefits under this contract.

BlueCross BlueShield
of Alabama

450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service:

988-2200 (in Birmingham)
or 1-800-292-8868 toll-free

Preadmission Certification:

988-2245 (in Birmingham)
or 1-800-248-2342 toll-free

Rapid Response:

988-5401 (in Birmingham)
1-800-248-5123 toll-free

Website:

www.BCBSAL.com

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Health and Dental Plan

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